

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-003714

446

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED JAN 22 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (if outside corporate limits, give TOWNSHIP only)

ST. LOUIS

Length of stay in 1b

c. FULL NAME OF (if NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

3618 ARSENAL

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

c. CITY

OR

TOWN

ST. LOUIS

Inside Limits

Yes ☐ No ☐

d. STREET

ADDRESS

(If outside, give location)

3618 ARSENAL

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED:

(Type or print)

First

Middle

Last

FRANK KIRTZ

4. DATE

Month

Day

Year

JAN 13

1963

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married

Widowed ☒

8. DATE OF BIRTH

Never Married ☐ Divorced ☐

9. AGE (last birthday)

FEB 26 1896

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PHYSICIAN

11. BIRTHPLACE (City and state or country)

MO. U.S.A.

13a. FATHER'S NAME

PHILIP KIRTZ

13b. MOTHER'S MAIDEN NAME

MARY LOESCH

14. NAME OF HUSBAND OR WIFE

ELODIA KIRTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

331X

17. INFORMANT

ELODIA KIRTZ 3618 ARSENAL

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) CARDIAC FAILURE DUE TO IMPROPER MEDICATION.

DUE TO (c) CHRONIC NERVOUS DEGENERATION - PARKINSON'S DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

20b. SUICIDE

☐

20c. HOMICIDE

☐

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20e. TIME OF INJURY

Hour

a.m.

Month, Day, Year

20f. INJURY OCCURRED WHILE AT WORK

NOT WHILE AT WORK ☐

20g. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20h. CITY, TOWN, OR LOCATION

20i. COUNTY

20j. STATE

21. I attended the deceased from

MAY 1, 1962

to JAN 10, 1963

and last saw her alive on JAN 10, 1963

Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Dr. C. J. Phinabarger M.D.

(Degree or title)

22b. ADDRESS

3909 Miami St. Room 16 Mo.

22c. DATE SIGNED

1-15-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

1/15/63

23c. NAME OF CEMETERY OR CREMATORY

MISSOURI CEMETERY

23d. LOCATION (City, town, or county)

ST. LOUIS, MO.

(State)

24. FUNERAL DIRECTOR

Thomas Kirtz 2906 Grand

ADDRESS

25. DATE RECD. BY LOCAL REG.

JAN 15 1963

26. REGISTRAR'S SIGNATURE

Roan Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. A. Humphrey

Licensed Embalmer No.

#772

P. O. Address

2906 Gravel

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Mr. Humphrey

PA 2-3405
PA 3-2195